PRINTED: 01/31/2013 FORM APPROVED OMB NO. 0938-0391

1	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI A. BUIL		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		157249	B. WIN	G_		12/2	1/2012
	OVIDER OR SUPPLIER	,	•	STREET ADDRESS, CITY, STATE, ZIP COI 2255 STURDY RD VALPARAISO, IN 46383		DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ON SHOULD BE COMPLE HE APPROPRIATE DAT	
G 000	INITIAL COMMENTS	3	G	000			
	This was a federal has survey. This was an	ome health recertification extended survey.					
	Survey dates: 12/18/12 - 12/21/12						
	Facility: 006155						
	Medicaid #: 1002659	980A					
	Surveyor: Ingrid Mille	er, RN, PHNS					
	Skilled unduplicated						
	providing its own hon competency evaluate two (2) years beginni due to being found or Conditions of Particip	e, Inc. is precluded from the health aide training and/or on program for a period of the ng 01/02/2013 to 01/02/2015 the of compliance with the the pation 42 CFR 484.30 Skilled the 484.36 Home Health Aide					
		e Elder, MSN, BSN, RN y 2, 2013					
	1/28/13. je	lified as the result of an IDR					
G 101	484.10 PATIENT RIG		G	101			
		ight to be informed of his or must protect and promote rights.					
	Based on home visit	not met as evidenced by: observation, interview,					
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: IN006155

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		157249				12/2	1/2012
	OVIDER OR SUPPLIER		.	2	EET ADDRESS, CITY, STATE, ZIP CODE 255 STURDY RD (ALPARAISO, IN 46383	, . <u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
G 101	review, the agency faright to be treated with of 3 home visit observed home health aide preaffect all patients recesservices. Findings 1. On 12/18/12 at 8: observation, Employed observed to give a paraburing the bath, Employed observed to give a paraburing the bath, Employed observed with a bath completed. The patient #1 with a bath for 6 minutes, not allow 2. Clinical record #1, evidenced a document of Rights" and signed that stated, "The patient treated with dignity." 3. The agency policy Rights" with a review patient has the right to 4. On 12/18/12 at 9:3 alternate administrated.	and agency document iled to ensure the patient's in dignity were honored for 1 vations (patient #1) with a sent with the potential to eiving home health aide 15 PM at a home visit the E, Home Health Aide, was intial bed bath to Patient #1. Hoyee E failed to cover in blanket as the bath was ent was undressed and inblanket or other covering eiving the patient dignity. Start of care 11/16/09, and titled "Patient / Client Bill by the patient on 11/16/09 ent has the right to be titled "Patient / Client Bill of date of 3/29/12 stated, "The pobe treated with dignity." 30 PM, Employee B, the per, indicated Employee E did for dignity during the partial		101			
		must comply with accepted ls and principles that apply					

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G 121	Continued From pag to professionals furni	e 2 shing services in an HHA.	G	12 [.]	1		
	Based on home visit policy review, the agreemployees followed a infection control for 2 home visit observation	not met as evidenced by: cobservation, interview, and ency failed to ensure all agency policies related to of 5 (patient #1 and #4) ons resulting in the potential diseases to other patients,					
	Findings						
	wash her hands before by turning on the wast kitchen sink. She us towel, to turn on the shands with the running patient's dish soap to and then she rubbed with the dish soap ar her wrists. After rins with her washed han	Health Aide, was observed to re starting care for patient #1 er with her hands at the ed her hands, not a paper faucets. After wetting her ng water, she used the papply soap to her hands her hands for 15 seconds and water. She did not washing, she turned off the faucet ds and then used the cloth to dry her hands before					
	b. The agency p with a review date of faucet on with a paper	at 4 PM, the administrator E did not follow the agency's res for handwashing. olicy titled "Handwashing" 3/29/12 stated, "Turn the er towel held between your E Discard the paper towel					

STATEMENT OF AND PLAN OF (DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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G 158	the running water A lather. Spread it over hands and wrists U motion for a minimum least 2 inches above thoroughly with paper to turn off the faucet." 2. On 12/19/12 at 11. Registered Nurse, wa oxygen saturation rate oximeter and did not cor after using it on the a. On 12/19/12 a indicated the pulse ox before and after use of and equipment shall be between patient conta 484.18 ACCEPTANC MED SUPER Care follows a written and periodically revier osteopathy, or podiate This STANDARD is read and interview, the age was provided as orde required by agency periodical to the state of the state o	ar hands and wrists under Apply soap. Work up a good the entire area of your lise a rotating and rubbing a of 15 seconds wash at the wrist Rinse well Dry towels. Use a paper towel as observed to assess the e of patient #4 with a pulse clean this equipment before e patient. It 11:45 AM, Employee H kimeter was to be disinfected on the patient. It 11:45 AM, Employee H kimeter was to be disinfected on the patient. Dicy titled "Infection Control" 3/29/12 stated, "Surfaces be cleaned, then disinfected act." E OF PATIENTS, POC, I plan of care established wed by a doctor of medicine, ric medicine. Into the medicine as evidenced by: ord review, policy review, ency failed to ensure care red on the plan of care or as olicy in 1 of 10 records ord #10) with the potential to		121			

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G 158	included a plan of car of 10/17/12 - 12/15/1 had a diagnosis of ar complications. This particles was to vin week 2, and once aneeded visits for incredesing or wound produced the plan of nurse to complete sk assessments includir assessments; bilatera monitoring swelling ir management of respicoughing deep / deep spirometer; rest / actimedication; pain medication; pain medication; pain medication of situated relieve pain; the need alternative pain contributes pain contributes, imagery, distrated administration technifor 3 liters of oxygen wound care noted was saline, apply silvader abdominal pads, and a. The start of cate by Employee C, RN (evidenced the patient left leg and was on 3	o, start of care 10/17/12, re with a certification period 2, that identified the patient open wound of the leg with clan of care evidenced the visit 1 time in week 1, 2 times a week for 6 weeks with as ease in wound drainage, roblems, falls, or labs. care evidenced the skilled in assessments; respiratory or lung sounds; pedal pulse al calf measurements for the lower legs; and the iratory exacerbations; to breathing exercises; use of vity schedule; oxygen and dication schedule; ions that exacerbate and di for rest and balanced diet; ol such as relaxation, hot action; and drug ques. There was no order per nasal cannula. The as to cleanse daily with the to wound, cover with	G	158			

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G 158	signed by Employee wound 3.5 cm long x The nurse stated, "Pa care performed. He wound air out for awh brought for patient. I able to start antibiotich him tomorrow. Left a well with minimal dra very excoriated / reaching provided or used for treatment oxygen with Saturation the wound] indurated reddened, weeping, reconsurrounding tissue: resolved and relieve pain, rein balanced diet, or teach techniques such as reimagery, or distraction c. A "SN [skilled signed by Employee nurse) on 10/25/12 sileg wound] open to a keep it open to hair at than to keep rewrapp lower extremities is we to apply silvadene to color both lower extrematics. There is closed blisters scatter	nurse] Progress Note" C on 10/22/12 evidenced a .5 cm width X .2 cm deep. atient refused to have wound she wanted to have the nile Wound care supplies informed me that he won't be a until his sister picks it up for interior leg wound healing inage, but surrounding skin addened / weeping. In cellulitis and clindamycin In patient on 3 liters of ion at 96 % Condition [of In, separated, excoriated, moist irregular us copious no odor and moist excoriated." The other pain medication ituations that exacerbate force need for rest and oth alternative pain control aleaxation, hot / cold packs, in. nurse] Progress note" J, LPN (licensed practical tated, "Right [implied right ir. Patient says it is easier to ind have it drain onto towel ing it. The skin on both ery scaly. I encouraged him weeping areas daily. The emities from the knee down imple color from venous are a multiple number of tiny	G	158			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	•	.	225	ET ADDRESS, CITY, STATE, ZIP CODE 55 STURDY RD LPARAISO, IN 46383		-
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G 158	treated for cellulitis." evidence measurem wound in the left leg blood pressure medi modifications includi regular exercise; pai establishing the pain teaching alternative relaxation; hot / cold distraction. d. A "SN Progre C, RN, on 11/1/12 fa medication schedule were identified that e were identified; need were reinforced; alte relaxation, hot / cold were taught; and ver medications were no The wound measure and 0 cm depth. e. A "SN Progre J on 11/5/12 failed to respiratory exacerba deep breathing exer- oxygen and medicat completed and that ta adequate relief of pa general notes stated moderate amount of allowed me to apply draining area. Area cellulitis is barely not both lower extremities	edness in the area that was The document failed to ent of wounds including the blood pressure; teaching of cations; teach lifestyle ng low sodium diet and n management including medication schedule and pain control such as packs, imagery, and ss note" signed by Employee iled to evidence that a pain was established; situations exacerbate and relieve pain for rest and balanced diet emative pain control such as packs, imagery, distraction realization of the purpose of ot verbalized by the patient. Ed. 2 cm length, 1.7 cm wide, ss note" signed by Employee of evidence management of intions including coughing / cises and management of ion management was the patient could verbalize unin or cope with pain. The	G	158			

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G 158	depth. The nurse als noted from open areanew wound was not written that the goal on the met and the patie effective blood press patient does not have f. A "SN Progre C on 11/12/12 failed management of respincluding coughing / were taught and the was taught; pain medestablished; situation exacerbate and relie for rest and balanced alternative pain control cold packs, imagery, verbalization of the post protocold packs, imagery, verbalizations; measure established a pain mustivations that exace reinforced need for malternative pain controlled packs, imagery, calves for edema. h. A "SN Progred J on 11/20/12 failed in the post progred packs, imagery, calves for edema.	gth. 4 cm. width, and 0 cm o wrote, "Weeping wound a on old laceration." This measured. The nurse had of stable oxygenation level is ent was unable to maintain ture management since the e a blood pressure machine. Ses Note" signed by Employee to evidence that irratory exacerbations deep breathing exercise use of oxygen equipment dication schedule was so were identified that we pain were identified; need a diet were reinforced; ol such as relaxation, hot / distraction were taught; and urpose of medications were	G	158			

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				DING 3			
		157249	D. WIIN	'——		12/	21/2012
	ROVIDER OR SUPPLIER			2255	ADDRESS, CITY, STATE, ZIP CODE STURDY RD PARAISO, IN 46383		
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G 158	of respiratory exacer breathing exercise, roxygen and medicatin a pain medication so that exacerbate and for rest and balanced control such as relax imagery, and distract The patient's goal of not met. The nurse system, "Symptoms is unable to exercise i. A "SN Progres C on 11/27/12 failed the management of roughing / deep breaspirometer, rest / act medication managem medication schedule exacerbated and relinneed for rest and bal alternative pain controlled packs, imagery, wrote that relief of patient's patient receivin Skilled nursing and his shall be in accordance patient's diagnosis at patient's immediate a resources."	bations, coughing / deep est / activity schedule, and on management; established hedule; identified situations relieve pain; reinforced need didiet; taught alternative pain ation, hot / cold packs, tions; checked pedal pulses. verbalized relief of pain was stated under Endocrine obesity - poorly controlled, to reduce his weight." The sest Note signed by Employee to evidence the nurse taught respiratory exacerbations, athing exercises, use of a sivity schedule oxygen and thent; established a pain reinforced the anced diet; and taught for such as relaxation, hot / distractions. The nurse ain goals was not met. The titled "Plan of care" with a 2 stated, "A current written are shall be developed for g care from the agency. The one health aide services are with a plan based on the and long range needs and to titled "Acceptance of w date of 3/29/12 stated," titled "Acceptance of w date of 3/29/12 stated,"	G	158			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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G 158	quality services to the meets the qualifying of accepted for treatmer reasonable expectation nursing, and social new the agency in the puriodical, nursing need patient and / or careg commitment and willing treatment plan Meet written medical plan of periodically reviewed 4. The agency policy Protocol" with a reviet is the policy of the agest practices for the optimal wound healing patient, physician, an staff shall work toward healed wound. Proceed measured with the disdevice and photographics.	ated to providing safe, ose patients whose condition criteria patients are not on the basis of a contact the patient's medical, eeds can be met adequately patient's place of residence cased upon the patient's ds and / or request The ivers must indicate a ngness to cooperate with the dical care shall follow a of care established and by the physician." It titled "Wound Care we date of 3/29/12 stated, "It ency to incorporated nursing benefit of the patient and for g. In coordination with the d wound clinic, the agency d an infection free and edure: 1. Wounds shall be sposable wound measuring of the possible wound measuring of the patient in wound contact in wound contact in wound contact in wound contact in wound	G	158			
G 159	director of nursing inc #10 the skilled nurse plan of care. 484.18(a) PLAN OF 0 The plan of care deve the agency staff cove	io PM, the administrator / licated that in clinical record did not follow the written CARE eloped in consultation with rs all pertinent diagnoses, us, types of services and	G	159			

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2255 STURDY RD	2/21/2012
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
ASSOCIATED HOMECARE INC VALPARAISO, IN 46383	045)
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Continued From page 10 equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on clinical record and agency policy review, observation, and interview, the agency failed to ensure the clinical records contained plans of care that included all of the required items in 3 of 10 (45,3 #4, and #10) patient records reviewed creating the potential to affect all of the agency's patients. Findings 1. Clinical record #3, start of care (SOC) 11/12/12, included a plan of care for the certification period of 11/12/12 - 1/10/13 that failed to evidence the patient had an oxygen concentrator and an order for oxygen at 4 liters per nasal cannula. a. On 12/19/12 at 10 AM, patient #3 was observed to have an oxygen concentrator in the home and was on 4 liters of oxygen per nasal cannula. The patient had a CPAP (Continuous positive airway pressure) machine at the bedside. b. On 12/19/12 at 10 AM, patient #3 indicated the CPAP machine was used at night. c. On 12/21/12 at 2:10 PM, the administrator	

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G 159	oxygen or the oxygen machine for nighttime d. A "SN Progreand signed by Emplo CPAP machine next to times at 4 liters per not times at 4 liters per not 2. Clinical record #4, plan of care for the co-2/14/13 that failed a CPAP machine for pump that had been so 10/18/12. a. On 12/19/12 a indicated the baclofer surgically implanted of for medication adminimachine was used with b. On 12/19/12 a observed to have a Cobedside. c. On 12/19/12 a indicated plan of care pump, the medication pump, or the CPAP modulation of care for the co-12/15/12 that failed oxygen. a. A clinical documerse] Progress note:	e concentrator or the CPAP e use on the plan of care. SS Note" dated on 11/20/12 yee H stated, "Discussed o bed wears oxygen at all asal cannula." SOC 4/27/11, included a certification period of 12/17/12 to evidence the patient had use at night and a baclofen surgically implanted on at 11:30 AM, patient #4 in pump which had been on 10/18/12 was being used istration and the CPAP inile he / she slept. at 11:30 AM, patient #4 was PAP machine at the at 2:30 PM, the administrator of did not include the baclofen or ordered with the baclofen	G	159			

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G 159	refused to have wound wanted to have the wanted to have to have to agency (See G 170), registered nurse made wanted to have made and market wanted to have the	The nurse stated, "Patient of care performed. He / she ound air out for awhile oxygen with Saturation at 96 and document titled "SN as note: 11/5/12" with a e J, licensed practical nurse, ygen oxygen per nasal at 3:30 PM, the administrator or indicated the oxygen was not at 3:40 PM, the administrator or indicated the oxygen was not at 3:40 PM, the administrator or indicated the oxygen was not at 3:50 PM, the administrator		168		
	to affect all patients o	s reviewed with the potential f the agency (see G 173, he licensed practical nurse				

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G 168	policy for 1 of 10 reco potential to affect all t who were cared for by (see G 179.	accordance with agency	G 1	68		
G 170	resulted in the agency	y's inability to be in condition 42 CFR 484.30 ces.	G 1	70		
	The HHA furnishes sk accordance with the p	cilled nursing services in olan of care.				
	Based on clinical rec and interview, the age skilled nurse provided care in 1 of 10 record	not met as evidenced by: ord review, policy review, ency failed to ensure the I as ordered on the plan of s reviewed (Clinical record I to affect all patients of the				
	Findings					
	included a plan of car of 10/17/12 - 12/15/12 had a diagnosis of an complications. This p skilled nurse was to v in week 2, and once a needed visits for incre dressing or wound pro However, the plan of nurse to complete ski	e with a certification period 2, that identified the patient open wound of the leg with plan of care evidenced the isit 1 time in week 1, 2 times a week for 6 weeks with as ease in wound drainage, oblems, falls, or labs. care evidenced the skilled in assessments; respiratory g lung sounds; pedal pulse				

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	ROVIDER OR SUPPLIER		•	22	EET ADDRESS, CITY, STATE, ZIP CODE 255 STURDY RD ALPARAISO, IN 46383		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
G 170	assessments; bilatera monitoring swelling in management of respi coughing deep / deep spirometer; rest / actimedication; pain medidentification of situatirelieve pain; the need alternative pain contropacks, imagery, distradministration technic for 3 liters of oxygen wound care noted was aline, apply silvaden abdominal pads, and a. The start of caby Employee C, RN (evidenced the patient left leg and was on 3 measured 7 cm (cent 0.2 cm deep. b. A "SN [skilled signed by Employee wound 3.5 cm long x The nurse stated, "Pacare performed. He / wound air out for awh brought for patient. In able to start antibiotic him tomorrow. Left a well with minimal drai very excoriated / reTeaching provided on used for treatment oxygen with Saturation	al calf measurements for the lower legs; and the ratory exacerbations; breathing exercises; use of vity schedule; oxygen and ication schedule; ons that exacerbate and for rest and balanced diet; of such as relaxation, hot action; and drug ques. There was no order per nasal cannula. The sto cleanse daily with e to wound, cover with wrap with kerlix. The assessment completed Registered Nurse), 10/17/12 had an open wound to the liters of oxygen. The wound imeter)long x 0.9 cm wide x on 10/22/12 evidenced a second to have wound she wanted to have the ile Wound care supplies informed me that he won't be until his sister picks it up for interior leg wound healing nage, but surrounding skin	G	170			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL	JLTIPLE CONST	RUCTION	(X3) DATE SUF	
		157249	B. WIN	3		12/2	1/2012
	ROVIDER OR SUPPLIER			2255 STUR	RESS, CITY, STATE, ZIP CODE DY RD IISO, IN 46383	12/2	172012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 170	surrounding tissue: r SN did not establish s schedule or identify s and relieve pain, rein balanced diet, or tead techniques such as r imagery, or distractio c. A "SN [skilled signed by Employee nurse) on 10/25/12 s leg wound] open to a keep it open to hair a than to keep rewrapp lower extremities is v to apply silvadene to color both lower extre are a dark reddish pu insufficiency. There closed blisters scatte extremities especially I do not see any re treated for cellulitis." evidence blood press pressure medications modifications includir regular exercise; pair establishing the pain teaching alternative p relaxation; hot / cold distraction. d. A "SN Progres C, RN, on 11/1/12 fai medication schedule	moist irregular us copious no odor ed moist excoriated." The the pain medication ituations that exacerbate force need for rest and ch alternative pain control elaxation, hot / cold packs, n. nurse] Progress note" J, LPN (licensed practical tated, "Right [implied right ir. Patient says it is easier to nd have it drain onto towel ing it. The skin on both ery scaly. I encouraged him weeping areas daily. The emities from the knee down imple color from venous are a multiple number of tiny red all over the lower of the ankles and top of feet dness in the area that was The document failed to sure; teaching of blood six teach lifestyle ing low sodium diet and in management including medication schedule and opain control such as	G	170			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		CONSTRUCTION	(X3) DATE SU COMPLE	
		157249		3		12/5	21/2012
	ROVIDER OR SUPPLIER TED HOMECARE INC			2255	T ADDRESS, CITY, STATE, ZIP CODE S STURDY RD PARAISO, IN 46383		172012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (ENCY)	ULD BE	(X5) COMPLETION DATE
G 170	were reinforced; alter relaxation, hot / cold were taught; and very medications were not and 0 cm depth. e. A "SN Progress or oxygen and medications deep breathing exercoxygen and medication completed and that the adequate relief of participation general notes stated, moderate amount of allowed me to apply draining area. Area is cellulitis is barely not both lower extremities from the venous stated measured .5 cm. lend depth. The nurse also noted from open area nurse had written that oxygenation level is a unable to maintain el management since the blood pressure mach. f. A "SN Progress C on 11/12/12 failed management of respincluding coughing / were taught and the was taught; pain medications."	for rest and balanced diet mative pain control such as packs, imagery, distraction balization of the purpose of t verbalized by the patient. d .2 cm length, 1.7 cm wide, d .2 cm length, 1.7 cm wide, ss note" signed by Employee evidence management of tions including coughing / sises and management of on management was ne patient could verbalize in or cope with pain. The "Left lower leg had serous drainage. [He / she] an abd [abdominal] pad to that is being treated for iceable to me. The tissue of is a purplish discoloration is." The left leg wound gth. 4 cm. width, and 0 cm or wrote, "Weeping wound a on old laceration." The it the goal of stable not met and the patient was fective blood pressure ne patient does not have a sine.	G	170			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILE	TIPLE CONSTRUCTION DING	(X3) DATE S COMPLI	
		157249	B. WING		12	/21/2012
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2255 STURDY RD VALPARAISO, IN 46383	<u>,</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 170	exacerbate and relieve for rest and balanced alternative pain controlled packs, imagery, verbalization of the post verbalized by the g. A "SN Progred Jon 11/15/12 failed to assessed vital signs; assessment, taught to medications; measure established a pain misituations that exacer reinforced need for realternative pain controlled packs, imagery, calves for edema. h. A "SN Progred Jon 11/20/12 failed to measured the wound of respiratory exacerly breathing exercise, recoxygen and medication soft that exacerbate and iffor rest and balanced control such as relaxing imagery, and distract The patient's goal of not met. The nurse so system, "Symptoms is unable to exercise"	ve pain were identified; need didet were reinforced; of such as relaxation, hot / distraction were taught; and urpose of medications were patient. Sess Note" signed by Employee of evidence the nurse completed a respiratory he use of blood pressure red the patient's wounds; redication schedule; identified roated and relieved pain; rest and balanced diet; taught roal such as relaxation, hot / distraction; or measured Sess Note" signed by Employee of evidence the nurse las; taught the management roations, coughing / deep rest / activity schedule, and relieve pain; reinforced need didet; taught alternative pain relieve pain reliev	G 1	70		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	ULTIPL LDING	E CONSTRUCTION	(X3) DATE SUF COMPLET	
		157249	B. WIN	IG		12/2	1/2012
	OVIDER OR SUPPLIER			22	EET ADDRESS, CITY, STATE, ZIP CODE 55 STURDY RD ALPARAISO, IN 46383	•	-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 170	coughing / deep brea spirometer, rest / acti medication managem medication schedule; exacerbated and relie need for rest and bala alternative pain controlled packs, imagery, wrote that relief of p	thing exercises, use of vity schedule/ oxygen and vent; established a pain identified situations that eved pain; reinforced the anced diet; and taught of such as relaxation, hot / distractions. The nurse in goals was not met. It titled "Plan of care" with a 22 stated, "A current written are shall be developed for go care from the agency. One health aide services with a plan based on the aid assessment of the and long range needs and attitled "Acceptance of a date of 3/29/12 stated, atted to providing safe, ose patients whose condition criteria patients are not not he basis of a con that the patient's medical, eds can be met adequately potatient's place of residence of assed upon the patient's dis and / or request The ivers must indicate a nigness to cooperate with the dical care shall follow a of care established and	G	170			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUII				
		157249	B. WIN	G		12/2	1/2012
	OVIDER OR SUPPLIER			22	EET ADDRESS, CITY, STATE, ZIP CODE 155 STURDY RD ALPARAISO, IN 46383		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 170		licated that in clinical record did not follow the written		170			
	The registered nurse necessary revisions.	initiates the plan of care and					
	Based on home visit review, policy review, failed to ensure the re revisions to the plan of reviewed (Clinical red	not met as evidenced by: observation, clinical record and interview, the agency egistered nurse made of care in 3 of 10 records ord #3, 4, and 10) with the oatients of the agency.					
	Findings						
	failed to evidence the revised the plan of ca	olan of care for the 11/12/12 - 1/10/13 that registered nurse had re to include the patient had for and an order for oxygen					
	observed to have an observed to have and was on 4 licannula. The patient	at 10 AM, patient #3 was oxygen concentrator in the ters of oxygen per nasal had a CPAP (Continuous ure) machine at the bedside.					
		at 10 AM, patient #3 nachine was used at night.					
	c. On 12/21/12 a	at 2:10 PM, the administrator					

Facility ID: IN006155

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	
		157249	B. WIN	IG_		12/2	1/2012
	OVIDER OR SUPPLIER		l l	2	REET ADDRESS, CITY, STATE, ZIP CODE 2255 STURDY RD /ALPARAISO, IN 46383		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 173	indicated there were roxygen or the oxygen machine for nighttime d. A "SN Progres and signed by Employ CPAP machine next to times at 4 liters per national	no orders for the 4 liters of concentrator or the CPAP use on the plan of care. So Note" dated on 11/20/12 yee H stated, "Discussed o bed wears oxygen at all asal cannula." SOC 4/27/11, included a critification period of 12/17/12 to evidence the skilled nurse of care to include the patient for use at night and a lad been surgically implanted at 11:30 AM, patient #4 in pump which had been sur 10/18/12 was being used stration and the CPAP hile he / she slept. at 11:30 AM, patient #4 was PAP machine at the	G	173			

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV AN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING (X3) DATE SURV COMPLETE						
		157249	B. WIN	IG		12/2	1/2012
	OVIDER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODE 255 STURDY RD /ALPARAISO, IN 46383	12/2	172012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 173	a. A clinical docunurse] Progress note: 10/22/12 evidenced awidth X .2 cm deep. refused to have wour wanted to have the wpatient on 3 liters of w" b. A clinical reconsignature of Employe stated, "Receiving ox cannula." c. On 12/20/12 and / director of nursing in on the plan of care.	ument titled "SN [skilled ' signed by Employee C on a wound 3.5 cm long x .5 cm The nurse stated, "Patient ad care performed. He / she ound air out for awhile oxygen with Saturation at 96 and document titled "SN as note: 11/5/12" with a a e J, licensed practical nurse, aygen oxygen per nasal at 3:30 PM, the administrator adicated the oxygen was not titled "Plan of Care" with a	G	173			
G 179	physician's plan of call each patient receiving Procedure 1. The plate pertinent diagnosis medications, treatmet 484.30(b) DUTIES OF PRACTICAL NURSE. The licensed practical accordance with ager. This STANDARD is reported by the second interview, the ager.	nts, and procedures." F THE LICENSED I nurse furnishes services in	G	179			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI		CONSTRUCTION	(X3) DATE SUF COMPLET	
		157249	B. WIN	G		12/2	1/2012
	OVIDER OR SUPPLIER			225	T ADDRESS, CITY, STATE, ZIP CODE S STURDY RD PARAISO, IN 46383		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 179	reviewed (clinical record affect all the patients cared for by a license findings 1. Clinical record #10 included a plan of car of 10/17/12 - 12/15/12 had a diagnosis of an complications. This patients was to vin week 2, and once a needed visits for incredures of the complete ski assessments including assessments; bilatera monitoring swelling in management of respicoughing deep / deep spirometer; rest / actimedication; pain medication; pain medication; pain medication; pain medication of situat relieve pain; the need alternative pain contropacks, imagery, distrated administration technic for 3 liters of oxygen wound care noted was saline, apply silvaden abdominal pads, and a. A "SN [skilled signed by Employee of the care of the patients of the care of the pads, and as the patients of the pads and as the patients of t	ncy policy for 1 of 10 records ord #10) with the potential to of the agency who were d practical nurse. In the start of care 10/17/12, we with a certification period 2, that identified the patient open wound of the leg with olan of care evidenced the sist 1 time in week 1, 2 times as week for 6 weeks with as ease in wound drainage, oblems, falls, or labs. In care evidenced the skilled on assessments; respiratory g lung sounds; pedal pulse at calf measurements for the lower legs; and the ratory exacerbations; or breathing exercises; use of wity schedule; oxygen and ication schedule; ions that exacerbate and if for rest and balanced diet; on such as relaxation, hot action; and drug ques. There was no order over nasal cannula. The set ocleanse daily with et o wound, cover with	G	179			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		PLE CONSTRUCTION G	(X3) DATE SUR COMPLETE	
		157249	B. WIN	IG_		12/2 ⁻	1/2012
	OVIDER OR SUPPLIER		•	2	REET ADDRESS, CITY, STATE, ZIP CODE 2255 STURDY RD VALPARAISO, IN 46383		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
G 179	keep it open to hair at than to keep rewrappilower extremities is very to apply silvadene to color both lower extremare a dark reddish purinsufficiency. There are closed blisters scatter extremities especially I do not see any retreated for cellulitis." evidence measurement wound in the left leg, blood pressure medic modifications includin regular exercise; pain establishing the pain teaching alternative prelaxation; hot / cold pressure deep breathing exercise. J on 11/5/12 failed to respiratory exacerbating exercises and medication completed and that the adequate relief of pain general notes stated, moderate amount of sallowed me to apply a draining area. Area the cellulitis is barely notion both lower extremities from the venous stasis measured .5 cm. length ending the color of the	r. Patient says it is easier to and have it drain onto towel ing it. The skin on both ery scaly. I encouraged him weeping areas daily. The mities from the knee down rple color from venous are a multiple number of tiny red all over the lower the ankles and top of feet dness in the area that was The document failed to ant of wounds including the blood pressure; teaching of actions; teach lifestyle g low sodium diet and management including medication schedule and ain control such as backs, imagery, and s note" signed by Employee evidence management of ions including coughing / ises and management of ion management was be patient could verbalize in or cope with pain. The	G	179			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	157249		B. WIN			12/21/2012		
NAME OF PROVIDER OR SUPPLIER ASSOCIATED HOMECARE INC				22	EET ADDRESS, CITY, STATE, ZIP CODE 55 STURDY RD ALPARAISO, IN 46383			
(X4) ID PREFIX TAG					LD BE	(X5) COMPLETION DATE		
G 179	new wound was not written that the goal on the patie effective blood press patient does not have c. A "SN Progred J on 11/15/12 failed the assessed vital signs; assessment, taught the medications; measure established a pain mustivations that exace reinforced need for malternative pain control cold packs, imagery, calves for edema. d. A "SN Progred J on 11/20/12 failed the measured the wound of respiratory exacer breathing exercise, moxygen and medication so that exacerbate and for rest and balanced control such as relax imagery, and distract The patient's goal of not met. The nurse system, "Symptoms is unable to exercise 2. The agency policy review date of 3/29/1	e 24 a on old laceration." This measured. The nurse had of stable oxygenation level is ent was unable to maintain ure management since the e a blood pressure machine. Ses Note" signed by Employee to evidence the nurse completed a respiratory the use of blood pressure red the patient's wounds; edication schedule; identified rbated and relieved pain; est and balanced diet; taught rol such as relaxation, hot / distraction; or measured Ses Note" signed by Employee to evidence the nurse is; taught the management bations, coughing / deep est / activity schedule, and on management; established hedule; identified situations relieve pain; reinforced need if diet; taught alternative pain ation, hot / cold packs, tions; checked pedal pulses. verbalized relief of pain was stated under Endocrine obesity - poorly controlled, to reduce his weight." y titled "Plan of care" with a 2 stated, "A current written are shall be developed for	G	179				

Facility ID: IN006155

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		157249	B. WING		12/21/2012	
NAME OF PROVIDER OR SUPPLIER ASSOCIATED HOMECARE INC			S	TREET ADDRESS, CITY, STATE, ZIP CODE 2255 STURDY RD VALPARAISO, IN 46383		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
G 179	each patient reviving Skilled nursing and he shall be in accordance patient's diagnosis ar patient's immediate a resources." 3. The agency policy Protocol" with a revie is the policy of the ag best practices for the optimal wound healin patient, physician, an staff shall work towar healed wound. Proce measured with the dis device and photograp	care from the agency. Dome health aide services e with a plan based on the ad assessment of the and long range needs and titled "Wound Care w date of 3/29/12 stated, "It ency to incorporated nursing benefit of the patient and for g. In coordination with the d wound clinic, the agency d an infection free and edure: 1. Wounds shall be esposable wound measuring whed on Mondays or the first Any deterioration in wound	G 17	79		
G 202	director of nursing inc	FO PM, the administrator / licated the licensed practical gency policy in clinical FH AIDE SERVICES	G 20)2		
	Based on policy review home visit observation determined the agency registered nurse prepand clear instructions of patients with home observed at home visits.	not met as evidenced by: ew, clinical record review, n, and interview, it was ey failed to ensure the ared complete, appropriate, for 4 of 5 records reviewed health aide services its with the potential to ts receiving aide services				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
				B. WING			
NAME OF DR	OVIDER OR SUPPLIER	157249				12/2	1/2012
ASSOCIATED HOMECARE INC				2	IEET ADDRESS, CITY, STATE, ZIP CODE 255 STURDY RD (ALPARAISO, IN 46383		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 202	nurse assigned appro- health aide for 1 of 5 visits with home healt potential to affect all of services (See G 225)	d to ensure the registered opriate tasks to the home patients observed at home th aide services with the of the patients receiving aide	G	202			
G 224	resulted in the agency health aide care was		G	224			
	health aide must be p nurse or other appropresponsible for the su	nstructions for the home prepared by the registered prize professional who is apervision of the home agraph (d) of this section.					
	Based on policy review home visit observation failed to ensure the recomplete, appropriate of 5 records reviewed with home health aided.	not met as evidenced by: ew, clinical record review, n, and interview, the agency egistered nurse prepared e, and clear instructions for 4 I of patients (#1,2, 3 and 4) e services observed at home al to affect all of the patients es.					
	Findings include						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		157249	B. WIN			12/21/2012		
NAME OF PROVIDER OR SUPPLIER ASSOCIATED HOMECARE INC				2255	FADDRESS, CITY, STATE, ZIP CODE STURDY RD PARAISO, IN 46383			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	(X5) COMPLETION DATE		
G 224	health aide (HHA). a. On 12/18/12 indicated she had no months. b. On 12/18/12 alternate administrat written instructions for home. 2. On 12/19/12 at 7: folder evidenced writ dated 10/28/10 for the patch at bedtime. a. A clinical doctitled "Aide only" and 7 PM - 9 PM and signed by Emploe "Medication adocument from patie and dated on 12/12/2 and signed by Emploe "Medication assistantob. On 12/21/12 indicated taking the lat the last visit she hindicated wearing glointo the trash. This we the medication assistantob. On 12/21/12 indicated taking the lat the last visit she hindicated wearing glointo the trash. This we the medication assistantob. On 12/21/12 indicated taking the lat the last visit she hindicated wearing glointo the trash. This we the medication assistantoble trash.	at 8:15 PM, Employee E t seen an aide care plan for at 9:10 PM, Employee B, the or, indicated there were no or the HHA in the patient's 30 AM, patient #2's home ten patient care instructions e aide to remove a lidoderm ument from patient 2's record dated on 12/1/12 and timed ned by Employee K, HHA assistance." A clinical nt 2's record titled "Aide only" 12 and timed 7 PM - 9 PM byee O, HHA, stated,	G	224				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		157249	B. WIN			12/21/2012		
NAME OF PROVIDER OR SUPPLIER ASSOCIATED HOMECARE INC				225	ET ADDRESS, CITY, STATE, ZIP CODE 55 STURDY RD LPARAISO, IN 46383			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	(X5) COMPLETION DATE		
G 224	medication assist on 3. On 12/19/12 at 10 observation to patient documentation was fincluded written instructions present #3. On 12/19/12 at 11 indicated she was not aide instructions present included written instructions present included written instruction was fincluded written instruction was fincluded written instruction was patient #4. a. On 12/19/12 at 11 observation to patient documentation was fincluded written instruction was present included written instruction. b. On 12/19/12 at 11 observation to patient documentation was fincluded written instructions was present included written instruction. b. On 12/19/12 at 11 observation to patient was patient #4. b. On 12/19/12 at 11 observation to patient documentation was fincluded written instructions was present included written instructions. b. On 12/19/12 at 11 observation to patient was patient #4. 5. On 12/19/12 at 11 observation to patient was patient with a respective for the HHA the patient. 5. The agency policy Assignment" with a respective for the patient was present with a patient was present was presen	a part of her duties under the the aide care plan. 1:15 AM, a home visit the aide was made. No bound in the home that fuctions for Employee G, and in the home and caring for the aware there were written the sent in the home or home wisit.	G	2224				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		157249	157249 B. WING		12/21/2012		
NAME OF PROVIDER OR SUPPLIER ASSOCIATED HOMECARE INC				22	EET ADDRESS, CITY, STATE, ZIP CODE 255 STURDY RD ALPARAISO, IN 46383		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 224	patient the evaluatic complete a home heat the home health aid be updated whenever duties of the aide have be updated and reviee 6. The agency policy medication assistance 3/29/12 stated, "Home care attendance may assistance to an indivaccomplish the task of who is either competers services." 484.55(c) DRUG RECOMPANIES The comprehensive a review of all medicatic using in order to identificate and drug react drug therapy, significating interactions, dup noncompliance with composition of the services on clinical recomposition profile incomedication profile incomedications for 1 of 1 potential to affect all to #4). Findings	etermine the needs of the ng nurse shall then alth aide assignment sheet de assignment sheet shall or a change in the orders or the been amended, but shall wed at least every 60 days." It titled "Home Health aide: the "with a review date of the Health aide and personal provide medication ridual who is unable to the late to an impairment and the ent and has directed the and has directed the ansessment must include a const he patient is currently tify any potential adverse tions, including ineffective ant side effects, significant solicate drug therapy, and larug therapy. Interview, interview, and ency failed to ensure the		337			
		n profile had been updated					

Facility ID: IN006155

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
157249		157249	B. WINC	B. WING		12/21/2012	
NAME OF PROVIDER OR SUPPLIER ASSOCIATED HOMECARE INC				2255 S	DDRESS, CITY, STATE, ZIP CODE TURDY RD ARAISO, IN 46383		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
G 337	[skilled nurse] Progree "Spasms have decrea pump." b. On 12/19/12 a indicated a baclofen pimplanted and the me pump was reducing h c. A clinical docu Current" failed to evid medication. d. On 12/19/12 a / director of nursing in administered through updated to the medication. 2. The agency policy "The primary nurse contains to the medication."	f the patient's current as evidenced by the ord document titled "SN ss Note: 11/05/12" stated, ased with the baclofen at 11:30 AM, patient #4 pump was surgically edication given through the his muscle spasms." ument titled "Medications - dence the Baclofen as a at 2:30 PM, the administrator adicated the baclofen pump was not ation profile. It titled "Medications" stated, coordinating a patient's case for maintaining, updating and	G	337			